CMS ILLINOIS
DEPARTMENT OF CENTRAL
MANAGEMENT SERVICES

Risk Management Division

MEDICAL BILL TRANSMITTAL FORM

Re: Client Name: _____ CF#: _____ D/A: _____

Vendor Name: _____ SS#: _____or

Address: _____ FEIN: _____

_____ ACCOUNT#: _____

Received: _____ Dates of Service: From: _____ To: _____

Total Amount of Bill: $_____

Type of Service:

Facility #: _____ ☐ **WC 02 Medical** ☐ **WC 08 IME** ☐ **WC 11 Rehabilitation**

☐ **WC 12 Claims Management**

NOTE: When submitting a bill for payment, supporting documentation and attachments are required. If any of the information is missing, this transmittal form will be returned.

MEDICAL BILLS WILL BE RETURNED IF YOU HAVE NOT SUBMITTED THE PAPERWORK TO ESTABLISH A CLAIM.

In order for the office to process the above-mentioned bill, we must have the following:

_____ **Discharge Summary** _____ **Radiology Report** _____ **Emergency Room Report**
_____ **CT Scan Results** _____ **Medical Report** _____ **Prescription Names**
_____ **Test Result**

Approved for Payment: _____
(Adjuster Signature) (Date)

Denied for Payment: _____
(Adjuster Signature) (Date)

IL444-4198 (R-06-04)